

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K014		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/08/2014	
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6505 E 82ND ST STE 200 INDIANAPOLIS, IN 46250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{G 000}	<p>INITIAL COMMENTS</p> <p>This was a revisit for the Federal recertification survey completed on 3/25, 3/26, 3/27, 3/28, and 3/31/14 that resulted in an extended survey.</p> <p>An Immediate Jeopardy was identified on 03/31/14. The Administrator was notified of the Immediate Jeopardy on 03/31/14 at 3:45 PM. The Immediate Jeopardy remained unremoved at survey exit. The Immediate Jeopardy was removed with a survey conducted 4/22/2014.</p> <p>Survey Date: 5/08/14</p> <p>Facility #: 002773</p> <p>Medicaid Vendor #: 200456380</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Current Census: 122</p> <p>Two (2) conditions and 18 standards were found to be corrected during this survey.</p> <p>Maxim Healthcare Services is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 4/09/14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30 Nursing Services.</p> <p>The Home Health Director and the hospital Clinical Nursing Director were informed of this preclusion during the exit conference held on</p>			{G 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{G 000}	Continued From page 1 5/08/14 at 5:00 PM. Maxim Healthcare Services is in compliance with the Conditions of Participation 42 CFR 484. Quality Review: Joyce Elder, MSN, BSN, RN May 12, 2014	{G 000}			